Mental Health Prescription Drug Management

Texas, Georgia, Washington

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Texas Medicaid

Texas Medicaid has developed a preferred drug list and prior authorization protocol for psychotropic medications based around the Texas Medication Algorithm Project (TMAP). TMAP was implemented in 1996 with the goals of:

- Improving quality of care and patient outcomes for each resource expended
- Developing and regularly updating standards of practice algorithms to improve emotional, physical, and financial outcomes for patients, families, and the health care system.

TMAP developed flow-charts to guide physicians in making evidence-based decisions in the treatment of schizophrenia, major depressive disorder, and bipolar disorder. These algorithms do not dictate clinical decisions but provide a framework that will yield the most consistent and effective treatment of these disorders. Physicians are educated and given treatment manuals to help assess clinical failures and to define appropriate trial periods, dosing, and adverse effects. Preferred drugs represent therapeutically equivalent medications which should be considered first line. Prior authorizations are utilized for doses that exceed maximum threshold limits and the use of multiple agents from the same therapeutic class.

Atypical antipsychotics

Preferred Drugs	Abilify, Geodon, Invega, Seroquel, Seroquel XR, Zyprexa, risperidone
Non-preferred drugs (PA required)	clozapine, Clozaril, Fazaclo, Risperdal
Prior authorization criteria	• Treatment failure with preferred products OR • Contraindication to preferred products OR • Allergy to preferred products OR • Patients on a non-preferred product prior to enrollment will be authorized to continue on that product

Antidepressants

Preferred drugs	bupropion, bupropion SR, citalopram, Cymbalta, Effexor XR, fluoxetine, Lexapro, Luvox CR, mirtazapine, paroxetine, paroxetine CR, Pristiq, sertraline, trazodone, Venlafaxine ER
Non-preferred drugs (PA required)	Aplenzin, bupropion XL, Celexa, Desyrel, Effexor, Emsam, fluvoxamine, nefazodone, Paxil, Paxil CR, Pexeva, Prozac, Remeron, Sarafem, Wellbutrin, Wellbutrin SR, Wellbutrin XL, Zoloft
Prior authorization criteria	• Treatment failure with preferred products OR • Contraindication to preferred products OR • Allergy to preferred products OR • Patients on a non-preferred product prior to enrollment will be authorized to continue on that product

Georgia Medicaid

Georgia has adopted a step-therapy approach in regard to use of atypical antipsychotics and antidepressants. Preferred drugs should be considered first-line therapy. Non-preferred medications may be considered as the patient fails preferred therapy or meets specific prior authorization criteria. Patients started and stabilized on a non-preferred medication prior to Medicaid enrollment or during a hospitalization may continue therapy with that non-preferred medication with a written request (either a PA form or letter of necessity) from a physician. Stabilized is defined as being on the drug longer than two weeks or a reduction in symptoms with less than two weeks of treatment.

All prior authorization requests are either approved, denied, or pended for more information within one business day of receipt. Two levels of appeals are available, the first appeal is reviewed within 48 hours of receipt; the second is reviewed within 72 hours of receipt.

Atypical antipsychotics:

Preferred Drugs	Geodon, risperidone, Seroquel IR
Non-preferred Drugs (PA required)	Abilify, Fanapt, Invega, Risperdal, Saphris, Seroquel XR, Symbyax, Zyprexa
Non-preferred (PA not required)	Clozaril, clozapine, Fazaclo, Zyprexa inj

Prior authorization criteria:

Drug	Criteria
Abilify	• Bipolar disorder or schizophrenia diagnosis with 30 day trial period of 3 preferred drugs in last 12 months OR • Clinical justification of unacceptable preferred drugs OR • Children with a diagnosis of bipolar disorder or schizophrenia with a previous trial of risperidone OR • Bipolar disorder or schizophrenia diagnosis with family history of successful treatment with this product OR • Adjunctive therapy for major depressive disorder with failure of 2 SSRIs, Effexor, and Cymbalta
Fanapt or Invega	• At least 18 years old with schizophrenia diagnosis and 30 day trial period of 3 preferred drugs in last 12 months Or • Clinical justification of unacceptable preferred drugs OR • Family history of successful treatment with this product
Invega Sustenna or Zyprexa Relpevv	• Schizophrenia diagnosis with documented stabilization on this medication AND • Tried and failed or been noncompliant to the oral dosage form
Risperdal Consta	• Bipolar disorder or schizophrenia diagnosis with documented stabilization on this medication AND • Tried and failed or been noncompliant to the oral dosage form
Seroquel IR	• PA required for doses less than 100 mg
Seroquel XR	• Allergy, contraindication, drug interaction, or intolerable side effects to inactive ingredient in Seroquel IR AND • Must have a 30 day trial period of Geodon and risperidone in last 12 months or clinical

	justification of unacceptable preferred drugs OR • Adjunctive therapy for major depressive disorder with failure of 2 SSRIs, Effexor, and Cymbalta
Symbyax	• Should be used as two separate medications
Zyprexa	• 30 day trial period of 3 preferred drugs in last 12 month or clinical justification of unacceptable preferred drug OR • Bipolar disorder or schizophrenia diagnosis with family history of successful treatment with this product
Orally Disintegrating medications	• Non-disintegrating oral dosage formulations should be used

Antidepressants:

Preferred	All generic products, Lexapro, Paxil CR, Budeprion SR, Budeprion XL 300 mg, Effexor, Venlafaxine ER, Wellbutrin XL 150 mg
Non-preferred (PA Required)	All branded versions of generic equivalents, Luvox CR, Pexeva, paroxetine extended- release tablets, Aplenzin, Budeprion XL 150 mg, Cymbalta, Effexor XR, Pristiq, Sarafem, Selfemra, Savella, Wellbutrin SR (100 mg, 150 mg)

Prior authorization criteria:

Drug	Criteria
All (unless noted)	• Use of 2 preferred drugs within the last 12 months OR • Documentation of allergy, contraindication, drug interaction, or intolerable side effect to 2 preferred medications
Luvox CR	• Documentation of allergy, contraindication, drug interaction, or intolerable side effect to 2 preferred medications, 1 must be inactive ingredients in fluvoxamine
Paroxetine extended-release tablets	• Documentation of allergy, contraindication, drug interaction, or intolerable side effect to 2 preferred medications, 1 must be inactive ingredients in Paxil CR
Sarafem and Selfemra	• Requires prior trial of fluoxetine
Pristiq	• Documentation of allergy, contraindication, drug interaction, or intolerable side effect to 2 preferred medications, 1 must be venlafaxine IR, Effexor, or Venlafaxine ER (allergy must be to inactive ingredient)
Cymbalta	• Major depressive disorder or generalized anxiety disorder diagnosis AND • Documentation of allergy contraindication, drug interaction, or intolerable side effect to 2 preferred medications, 1 must be venlafaxine IR, Effexor, or venlafaxine ER
Budeprion SR/ buproprion SR/ Wellbutrin SR	• Diagnosis of major depressive disorder or seasonal major depressive episodes with seasonal affective disorder (not approvable for smoking cessation)
Savella	• Fibromyalgia diagnosis AND • Documentation of allergy, contraindication, drug interaction, or intolerable side effect to 2 of the following medications (Lyrica must be included): amitriptyline, cyclobenzaprine, fluoxetine, gabapentin, Lyrica, or tramadol
Budeprion XL 150 mg	• Documentation of allergy, contraindication, drug interaction, or intolerable side effect to 2 preferred medications, 1 must be the inactive ingredients of Wellbutrin XL 150 mg
Effexor XR	• Documentation of allergy contraindication, drug interaction, or intolerable side effect to 2 preferred medications, 1 must be the inactive ingredients of Venlafaxine ER
Aplenzin	• Documentation of allergy contraindication, drug interaction, or intolerable side effect to 2 preferred medications, 1 must be the inactive ingredients of budeprion XL 300 mg.

Washington Medicaid

Washington Medicaid has developed a therapeutic interchange program in conjunction with the preferred drug list. By endorsing this program, prescribers allow pharmacists to make appropriate therapeutic interchanges and dispense preferred drugs. Endorsing prescribers are able to obtain non-preferred drugs without a prior authorization by indicating the prescription is "dispense as written". The therapeutic interchange program does not currently apply to mental health medications however, psychotropic drugs are on the preferred drug list and prior authorization procedures may be applied. Atypical antipsychotics requiring prior authorizations are the injectable formulations and for doses exceeding maximum threshold limits. Prior authorizations for antidepressants occur when non-preferred drugs are prescribed by non-endorsing prescribers or endorsing prescribers who do not indicate "dispense as written". Prior authorization can be processed via phone or fax, and some drugs are available through an "expedited prior authorization" which will provide authorization at the pharmacy point-of-sale if the appropriate conditions are met.

Atypical antipsychotics

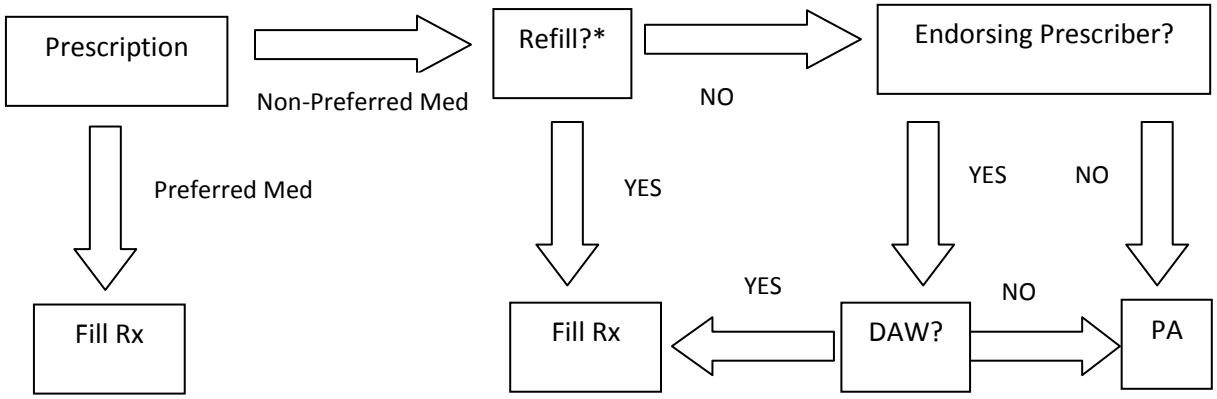
Preferred Drugs	Abilify*, clozapine, Fazaclo, Zyprexa*, Invega, Seroquel, Seroquel XR, Risperidal Consta* , risperidone, Geodon*
Non-preferred	Clozaril, Invega Sustenna*, Risperidal

*New patients requiring injectable forms may require prior authorization

Antidepressants

Preferred drugs	bupropion, bupropion SR, bupropion XL , budeprion SR, budeprion XL citalopram(tab, soln), fluoxetine, mirtazipine, paroxetine, paroxetine ER, sertraline, venlafaxine, Venlafaxine ER
Non-preferred drugs	Aplenzin, Celexa, Cymbalta, Effexor, Effexor XR, fluvoxamine, Lexapro, Luvox CR, nefazodone, Paxil, Pexeva, Pristiq, Prozac, Prozac Weekly, Rapiflux, Remeron, Selfemra, Serzone, Wellbutrin, Wellbutrin SR, Wellburtin XL, Zoloft

Handling of Preferred and Non-preferred Antidepressants



*Refill is defined as the continuation of a medication, including the renewal of a prescription or an adjustment in dosage. A prescription is considered a refill if it has been dispensed within the previous 180 days.

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